Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HCAA Medical Group, P.A.

Respondent Name
Safety National Casualty Corporation

MFDR Tracking Number
M4-15-3990-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 3, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE INSURANCE COMPANY WON'T PAY X-RAY STATING THAT IT WAS NOT FURNISHED DIRECTLY TO THE PATIENT. I HAVE ATATCHED THE CHARTING WITH THE X-RAY PORTION TO SUPPORT THE TREATMENT."

Amount in Dispute: $48.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bill in question for manual review to determine if additional monies are owed.

Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2015	Evaluation & Management, new patient (99202) X-Ray, Lumbar, 4 views, technical component (72110-TC-59)	$48.33	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the documentation requirements for bill submission.
3. 28 Texas Administrative Code §134.203 provides the fee guidelines for billing and reimbursing professional

medical bills.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 11 – (112) Service not furnished directly to the patient and/or not documented.
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Issues

1. Is the insurance carrier's denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The disputed service involves CPT codes 99202-25 and 72110-TC-59. The requestor is seeking $0.00 for CPT code 99202; therefore, this code will not be considered for the dispute. CPT Code 72110 is a professional service subject to the billing requirements found in 28 Texas Administrative Code §134.203, which states that billing is based on Medicare payment policies.

   The workers' compensation carrier (carrier) denied services with claim adjustment code 11 – "SERVICE NOT FURNISHED DIRECTLY TO THE PATIENT AND/OR NOT DOUCMENTED." Documentation requirements are established by 28 Texas Administrative Code §133.210 (b) and (c) which describe the documentation required to be submitted with a medical bill. 28 Texas Administrative Code §133.210 does not require documentation to be submitted with the medical bill for the services in dispute.

   Further, the process for a carrier's request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in section (d) of that section as follows:

   "Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

   No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d). The carrier's denial for this reason is not supported.

2. 28 Texas Administrative Code §133.307(c)(2) states in relevant part, "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division…The request shall include: (M) a copy of **all applicable medical records related to the dates of service in dispute**" [emphasis added].

   CPT code 72110 is defined as "Radiologic examination, spine, lumbosacral; minimum of 4 views." The modifier "TC" is defined as, "Technical component. Under certain circumstances, a charge may be made for the technical component alone… Technical component charges are institutional charges and not billed separately by physicians."

   Review of the submitted documentation does not find that the medical records support that the technical component of a four-view radiologic examination of the lumbar spine was performed on the date of service. Therefore, the requestor has not supported entitlement to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	October 6, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.